

Nebraska Department of Health & Human Services
Division of Public Health
Licensure Unit, PO Box 94986
Lincoln NE 68509-4986
(402) 471-2666 Fax (402) 471-1066

TRANSITION TO PRACTICE AGREEMENT

Nurse Practitioner Name _____ Phone (H) _____ (W) _____
Address _____ Nurse Practitioner License # _____
_____ Specialty _____
Supervising Provider Name _____ Phone _____
Address _____ License Type and # _____
_____ Specialty _____

The above named parties have developed this Transition to Practice Agreement and agree to the following: The Nurse Practitioner and supervising provider shall practice collaboratively within the framework of their respective scopes of practice; and

1. The Nurse Practitioner and supervising provider shall practice collaboratively within the framework of their respective scopes of practice; and
2. The Nurse Practitioner and supervising provider shall be responsible for his or her individual decisions in managing the health care of patients; and
3. The Nurse Practitioner and supervising provider shall have joint responsibility for patient care based upon the scope of practice of each practitioner; and
4. The supervising provider shall be responsible for supervision through ready availability for consultation and direction of the activities of the Nurse Practitioner within the Nurse Practitioner's defined scope of practice to ensure the quality of health care provided to patients.
5. The supervising provider and the Nurse Practitioner have a duty to notify the Department upon termination of this Agreement.

Nurse Practitioner

I _____ attest that I am the person referred to in this Transition to Practice Agreement as an Nurse Practitioner (NP) in the State of Nebraska; that the statements here in are true to the best of my knowledge and belief; and that I have read and understand the agreement.

Signature _____ Date _____
Nurse Practitioner

Supervising Provider

I _____ attest that I am the person referred to in this Transition to Practice Agreement as the supervising provider and that the statements herein are true to the best of my knowledge and belief; and that I have read and understand the agreement.

- ☐ I am a Nurse Practitioner who has completed 10,000 hours of practice as a Nurse Practitioner in Nebraska or another jurisdiction.
- ☐ I am a Physician licensed in the State of Nebraska.

Signature _____ Date _____
Supervising Provider

NOTE: It is your responsibility to notify the Department in writing when you have practiced 2,000 hours as a nurse practitioner.